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Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Peer Workforce

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

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Executive Summary

Peer recovery support services (PRSS) are social support services delivered by people who have lived experience with substance use disorders (SUDs) and mental health conditions. There is a growing understanding of and evidence base supporting the benefits of PRSS. Individuals who receive these services are more likely to stay engaged in the recovery process and are less likely to experience recurrence. Historically, PRSS were financed through federal grant programs, but in recent years Medicaid has become a significant payer.

The purpose of this report is to explore and summarize the financing, utilization, and regulatory structures of providing PRSS for SUD within federal grant programs and state Medicaid programs. Based on analyses and input from an expert panel of behavioral health peer services experts, the report identifies challenges and opportunities to finance and strengthen the PRSS workforce.

Federal grant programs that include PRSS were reviewed. Findings showed that although grants defined the role of peers, grantees had flexibility to propose activities and services provided by PRSS. This flexibility created variation in the role of and payment rates for PRSS.

To investigate the role of PRSS within state Medicaid plans, publicly accessible resources were reviewed to identify state-by-state reimbursement rates, certification requirements, and supervision requirements for PRSS. Analyses found that PRSS are available in nearly every state, and most state Medicaid plans reimburse peer support in 15-minute service intervals. Thirty states do not allow peers to supervise other peers and instead require clinically trained professionals to provide supervision. In addition, of the Medicaid plans with specific guidance on the types of staff eligible to supervise peer providers, only 11 states allow senior peers to be supervisors. Moreover, the use of PRSS for Medicaid beneficiaries throughout the United States remains very low compared with other SUD treatment and recovery services.

Research Questions

- What are the roles and requirements of PRSS in federal grant programs?
- Is there variation in state Medicaid plans' financing and utilization of PRSS?
- What are the key challenges and opportunities to strengthen the PRSS workforce?

An expert panel was convened by SAMHSA in May 2023. The panel emphasized that one of the challenges to increasing the availability and workforce for PRSS is Medicaid fee-for-service financing. Specifically, the panel noted the complexity of fitting PRSS practice into individual 15-minute increments, requirements regarding who supervises peer staff, and low Medicaid reimbursement rates. Other challenges to growing the PRSS workforce include inconsistent financing, low compensation, and a lack of clear guidance on the role and support of peers. Potential opportunities to overcome these challenges include unified federal government guidance on financing PRSS, infrastructure support, use of innovative payment models, and increased salaries for peer workers. Given the prevalence and severity of SUDs in this country, it is critical to support and expand the use of a SUD peer workforce.

CHAPTER 1

Introduction

In 2021, there were 106,699 drug overdose deaths that occurred in the United States.[1] An additional 140,000 deaths associated with excessive alcohol use occur each year in this country.[2] Approximately 48.7 million individuals, or 17.3 percent of the U.S. population, are estimated to have a substance use disorder (SUD).[3]

There is an urgent need to improve access to SUD treatment to address the recovery needs of individuals with a SUD. However, there is a shortage within the SUD service provider workforce.[4] This shortage is expected to worsen in the coming years, with the Department of Health and Human Services projecting an additional 20 percent reduction in the supply of the substance use and mental health services workforce by 2030.[4]

Expanding the peer recovery support services (PRSS)[5,6] workforce may be an effective and efficient way to bolster engagement with services and address parts of the ongoing challenges with meeting the treatment and recovery needs of individuals with a SUD. While PRSS cannot directly address clinical workforce needs, in conjunction with clinically focused SUD professionals, they can help support individuals with SUDs to find and sustain their recovery.

While PRSS were once supported primarily through federal grant programs, Medicaid has become a growing payer for these services. To support and grow PRSS, it is vital to understand the financing mechanisms used to fund them and the impact of the funding on the peer recovery specialist.

Peer recovery support services (PRSS)[5] are social support services delivered by peer recovery specialists (PRS).

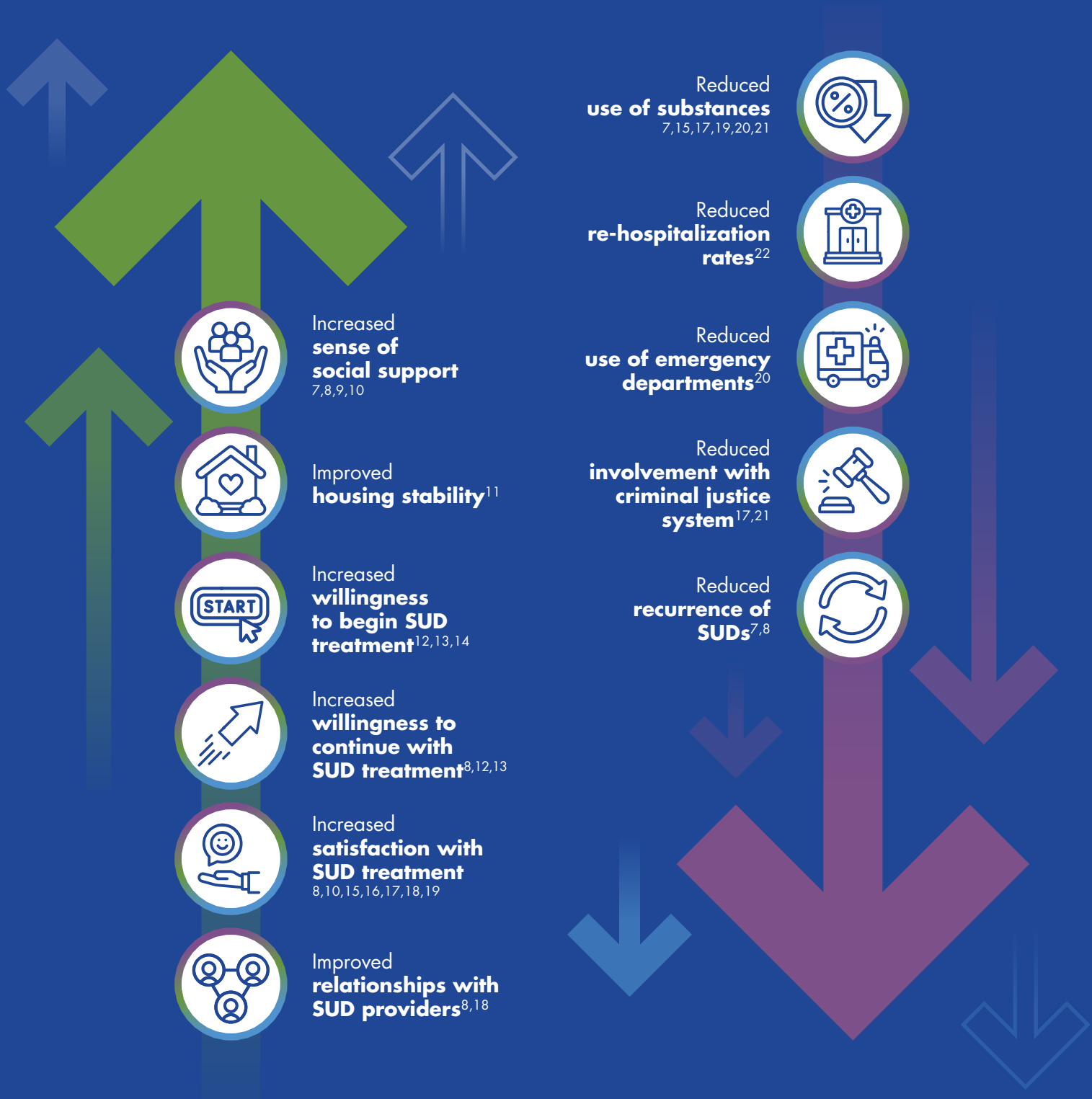
Peer recovery specialists[6] are people who have lived experience, either directly or through a dependent, involving a problematic mental health and/or substance use condition(s), who supports other people experiencing similar challenges in a range of nonclinical activities, including advocacy, linkage to resources, sharing of experience, social support, relationship and skill building, mentoring, goal setting, and more.

Other terms that refer to peer recovery specialists and can be used interchangeably in employment are the following:

- recovery coach
- peer specialist
- peer supporter
- peer worker
- mentor
- peer provider
- peer navigator

The purpose of this report is to explore and summarize the financing, utilization, and regulatory structures of PRSS for SUD within select federal grant programs and state Medicaid programs. Based on these findings and a panel discussion with subject matter experts, the report identifies opportunities to strengthen PRSS and improve financing for these services.

Outcomes Associated with PRSS for Addressing the Needs of Individuals with a SUD



Benefits and Growth of Peer Recovery Support Services

Volunteer peer-to-peer recovery supports, provided by 12-step programs and other mutual aid community programs, have helped many individuals in recovery or seeking recovery from SUD long before the introduction of the more formal PRSS that we see today.

Starting in the late 1990s and continuing into the 2000s, PRSS gained momentum as a component of some federal grant programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Through the use of grant funds and explicit guidance materials, SAMHSA encouraged communities to organize recovery-oriented systems of care inclusive of community-based recovery supports. Attention to the role and value of paraprofessionally trained PRSS grew from these efforts.

SAMHSA's 1998 grant program titled "Recovery Community Support Program" aimed to help members of the recovery community come together to organize and participate in public policy discussions and develop campaigns to combat stigma. This program was broad and focused on helping community organizations foster a recovery community that offered peer-to-peer support and worked toward sustained recovery from SUDs. In 2003, SAMHSA changed the name of this program to the Recovery Community Services Program (RCSP), and the agency began providing funding to grantees to develop and provide innovative PRSS in community settings. The RCSP provided the framework for the first round of the Access to Recovery (ATR) program in 2004. The program awarded grants to 14 states and one Indian Health Board for 3 years.

The ATR program allowed grantees to create a voucher system that gave clients a choice of eligible community providers to obtain needed recovery services, including PRSS. ATR guidance to grantees specifically noted that PRSS are allowable services payable through federal funds. However, in some states, peer-led recovery community organizations (RCOs) that employed trained peer recovery specialists were not considered eligible providers. Grantees were required to maintain a diverse network of community and faith-based organizations that offer treatment and recovery support services. ATR notices of funding opportunities were also available in 2007 and 2010. Each state program reported outcomes differently; for example, in Washington State it was found that ATR services were associated with a number of positive outcomes, including increased length of stay in treatment, increased likelihood of completing treatment, and increased likelihood of becoming employed.[23]

In 2011, SAMHSA funded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) to support the implementation of effective recovery supports and services for individuals with mental health needs or SUDs. BRSS TACS created numerous publications and tools to assist health care practitioners incorporate PRSS into their workflow.[24]

Then, in 2016, the Cures Act allowed many states to use new funds authorized by the legislation to expand recovery support services with State Targeted Response to the Opioid Crisis grants and State Opioid Response grants, in conjunction with state funds or the federal Substance Use Prevention, Treatment, and Recovery Services Block Grant.[25] Each state and territory had broad discretion to define, structure, and procure PRSS differently.

In 2021, SAMHSA initiated funding for the Peer Recovery Center of Excellence, a peer-led national center that provides training and technical assistance to enhance the field of PRSS.[26] The resources generated by this center provide a rich technical assistance base surrounding training, core competencies, outcome evidence, and state certification requirements for PRSS.[26]

SAMHSA continues to support the enhancement of the peer workforce through the creation of National Model Standards for Peer Support Certification.[27] The development of formalized PRSS certification standards and technical assistance has created a mechanism for health, criminal justice, and community-based service systems to use PRSS as a means to respond to the challenges of treating SUDs.

Select Milestones of Federal Support for Formalized Peer Recovery Support Services

1998
SAMHSA initiates the Recovery Community Support Program (RCSP) to support the recovery community to organize and participate in public policy discussions and address stigma

2003
SAMHSA funds a new cohort of RCSP grantees to provide direct PRSS in community settings

2004
SAMHSA funds the ATR grants designed to expand choice through the granting of vouchers to individuals with SUD for treatment and recovery support services, including PRSS

2007
The Centers for Medicare & Medicaid Services (CMS) releases guidance allowing peer services as a reimbursable evidence-based service if supervised by a "competent mental health professional as defined by the state"

2010
SAMHSA includes PRSS within the Substance Abuse Prevention and Treatment Block Grant application materials (currently as the Substance Use Prevention, Treatment, and Recovery Services [SUPTRS] Block Grant)

2012
SAMHSA launches the Recovery Community Services Program-Statewide Network (RCSP-SN) grant initiative to expand the capacity of addiction RCOs to be key partners in behavioral and physical health systems, and to strengthen the voice of the addiction recovery community at the local and state level

2013
CMS provides clarifying guidance reaffirming coverage for PRSS for use with SUDs and for parents and guardians with children under 18

2015
SAMHSA awards Targeted Capacity Expansion Peer-to-Peer (TCE-PTP) grants to expand and enhance service capacity through the provision of peer recovery support services for individuals with SUDs and their family members

2017
SAMHSA issues the Building Communities of Recovery (BCOR) grants to increase long-term recovery support from SUDs

SAMHSA issues the State Targeted Response (STR) and later the State Opioid Response (SOR) grants that allow state funding of PRSS

2021
The Health Resources and Services Administration (HRSA) issues the Rural Communities Opioid Response Program to address barriers to treatment in rural communities and includes PRSS

SAMHSA initiates the Peer Recovery Center of Excellence, a peer-led national center that provides training and technical assistance to enhance the field of PRSS

2022
The Bureau of Justice Assistance issues the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) to local entities, tribes, and states, and includes PRSS

SAMHSA issues the Treatment Drug Courts grants to public and private nonprofit entities, tribes, and tribal organizations, which include PRSS within the criminal justice system for the first time

Peer Recovery Support Services Are Provided in Many Settings

Substance Use Disorder Treatment Programs

Peer recovery specialists can offer individual, family, or group support, providing a unique perspective as someone who has also struggled with a SUD and is in recovery. Peers specialists are also an essential component of community-based mobile crisis intervention services.[16]

Hospitals

Peer recovery specialists work in emergency departments and inpatient units to offer emotional support and connection to essential services, including SUD treatment.

Peer Operated Community-Based Organizations

Peer recovery specialists are employed by community-based organizations that support individuals in recovery, often referred to as RCOs. These organizations may offer peer-led support groups, recovery coaching, or other services to help individuals sustain their recovery and reintegrate into their communities.[16] They also engage in community-based outreach and engagement efforts.[28]

Recovery Housing

Refers to safe, healthy, and substance-free living environments that support individuals in recovery from addiction. This housing is most often managed by peer supporters to maintain a structured and supportive environment. The National Alliance for Recovery Residences (NARR) provides guidance and technical assistance to state affiliates on certification criteria to drive enhanced quality and fidelity in this area of PRSS.[29]

Criminal Justice Settings

Peer recovery specialists provide peer support services to individuals involved in the criminal justice system, such as those in drug courts, prisons, or jails. SAMHSA has identified peer navigation as a best practice for successful reentry into communities from criminal justice settings for individuals with mental health and substance use conditions.[17]

Workplace or Educational Settings

Some employers or colleges offer PRSS as part of their employee and student wellness programs.

Via Technology

With the rise of telehealth and online support groups, PRSS can be delivered through digital platforms. This provides a convenient option for individuals who may not have access to in-person support or prefer the anonymity of online support.

The Role of and Need for Peer Workers

SAMHSA's "Core Competencies for Peer Workers in Behavioral Health Services" describes peer support as "offering and receiving help, based on shared understanding, respect, and mutual empowerment between people in similar situations." Regardless of the setting, function, or role of PRSS, the literature is clear that it is critical to maintain the inherent "peerness" of the support peer supporters provide.[30] Peer specialists also need support from trained supervisors experienced in delivering peer support to most effectively harness their lived experience to provide person-centered services.[31]

Recently, the Foundation for Opioid Response Efforts (FORE) funded a survey of peer workers.[32] The self-administered web survey was fielded from October 2022 to January 2023 in 11 states. Findings highlight that peer workers serve populations across many different service settings and perform a variety of tasks. The majority worked at RCOs or other community-based organizations, with the next largest groups working in courts and correctional systems or emergency department settings. The survey indicates that peer workers found current training and certification processes somewhat easy, and the majority of respondents reported great satisfaction with their role. However, low compensation and a lack of career advancement opportunities were noted challenges.[27]

The Biden administration released a strategy for to transform behavioral health services in the country. Expanding the behavioral health workforce, including increasing access to and improving the quality of the peer workforce, is part of that strategy.[33] There is a large gap to fill in the current PRSS workforce. However, with over 20 million individuals in the country living in recovery from SUD,[3] there is great potential to expand the workforce to meet the need for peer recovery specialists.

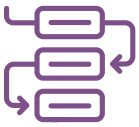
Medicaid as a Payer of Peer Recovery Support Services

Since the early 2000s, third-party reimbursement for PRSS has slowly emerged in public and private health programs, primarily state Medicaid plans. In 2007, CMS defined peer services as evidence-based and reimbursable services that could be deployed and financed in state Medicaid programs.[34] Until recently, Medicare did not allow PRSS for SUD in its general benefits plan. But the Consolidated Appropriations Act, 2023 allows for direct reimbursement of peer support specialists for mental health and SUD services.[35]

The key components of this PRSS guidance included the following:

Supervision

Supervision must be provided by a competent mental health professional as defined by the state.



Care Coordination

Peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

Training and Credentialing

Peer support providers must complete training and certification as defined by the state. Training must provide basic competencies to perform peer support services and must have ongoing continuing education requirements.

Peers must have lived recovery experience and demonstrate the ability to support the recovery of others.[34,36]

Initially, many states chose to limit Medicaid payment for peer support to beneficiaries with mental health conditions, and it was less common for states to pay for these services for beneficiaries with SUDs.[37] In 2013, CMS issued clarifying guidance to reaffirm that PRSS is reimbursable for addressing SUD. The guidance also clarified that peer-to-peer support services are available to parents/legal guardians of Medicaid-eligible children (aged 17 and younger). In 2019, CMS and SAMHSA issued a Joint Informational Bulletin about addressing mental health and substance use issues in schools and noted that peer supporters can play a critical role to help students.[38] States have increasingly included PRSS as part of their state Medicaid plans for addressing SUD. This is due to a number of factors, including the following:

- State response to the opioid epidemic, which has disproportionately affected Medicaid beneficiaries.[39]
- The Patient Protection and Affordable Care Act (ACA) established that SUD and mental health treatment must be covered at parity with physical health as an essential health benefit for individuals newly covered by Medicaid expansion.

Currently, PRSS for SUD is eligible for reimbursement by Medicaid programs in nearly every state, with several states adding the benefit to their state plans or waivers in just the last few years.[40] Despite Medicaid becoming a funding source for PRSS, in 2020 only 1.9 percent of identified SUD Medicaid claims were for PRSS.[41]

CHAPTER 2

Brief Summary of the Role of Peer Recovery Support Services in Grant Programs

To look at how the roles and delivery of peer recovery support services (PRSS) within federal grant programs contrast with PRSS paid for by Medicaid, select grant programs with significant PRSS requirements were identified. Reviews were conducted on publicly available documents such as federal descriptions of the grant programs, notices of funding opportunities, technical assistance and training materials, and other online content.

Programs from the following federal agencies were examined: Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Justice (DOJ), and the Health Resources and Services Administration (HRSA). It is important to note that grant programs where PRSS has historically been provided often are funded in conjunction with a range of other prevention, harm reduction, and treatment services.

Review of Notices of Funding and Technical Assistance Materials for Select Grant Programs

Information was gathered on the following topics, when available:

- Type of grantee recipient (e.g., state, community organization, mental health provider, etc.)
- Definition of the peer role
- Description of peer services provided
- Certification requirements of peer specialists
- Qualification of the peer specialist
- Information regarding payment for PRSS services
- Supervision requirements

The Value of PRSS According to SAMHSA's Working Definition of Recovery

"Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. By helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness."[42]

SAMHSA Grant Programs Reviewed

	Name of program (years reviewed for the notice of grant funding announcements)
1	Access to Recovery (ATR) (2004, 2010, 2014)
2	Building Communities of Recovery (BCOR) (2017, 2019, 2021, 2022)
3	Grants to Expand Substance Abuse Treatment Capacity in Adult and Family Drug Courts (SAMHSA Treatment Drug Courts) (2012, 2015, 2020, 2022, 2023)
4	Grants to Expand Substance Abuse Treatment Capacity in Targeted Areas of Need – Targeted Capacity Expansion-Local Recovery-Oriented Systems of Care (TCE-Local-ROSC) (2009, 2010)
5	Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS (MAI-High Risk Populations) (2014, 2019, 2022, 2023)
6	OD Treatment Access (2017, 2018, 2023)
7	Recovery Community Support Program (RCSP) (1998, 2001)
8	Recovery Community Services Program (RCSP) (2003, 2020, 2023)
9	State Targeted Response to the Opioid Crisis Grants (Opioid-STR) (2017), State Opioid Response (SOR) (2018-Current), Tribal Opioid Response (TOR) (2018-current)
10	Targeted Capacity Expansion: Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) (2016-current)

Health Resources and Services Administration and Department of Justice - Bureau of Justice Assistance Grant Programs

	Name of program (years reviewed for the notice of grant funding announcements)
1	Comprehensive Opioid, Stimulant, and Substance Abuse Site-Based Program (COSSAP) (DOJ: 2020, 2021, 2022)
2	DOJ Comprehensive Opioid Abuse Program (COAP) (DOJ: 2018, 2019)
3	Rural Communities Opioid Response Program - Implementation (RCORP-I) (HRSA: 2019, 2020, 2021, 2022)

The Value of PRSS as Described in Federal Technical Assistance Materials to Grantees

"When individuals exit addiction-treatment programs, or other institutions such as the military or correctional facilities, they often find themselves in families and communities that are ill-equipped and under-resourced to support their recovery. RCOs bridge critical gaps by providing peer support and services to help stabilize early recovery and sustain long-term recovery. They ensure that supports and services have an authentic recovery orientation grounded in community wisdom and experience. RCOs are uniquely equipped to promote recovery and dismantle barriers to achieving it."[43]

– Peer Recovery Center of Excellence

Summary of Grant Program Findings

Across grant programs, there are both differences and similarities in terminology and guidelines for defining PRSS by the federal agency involved and the year of publication of the notice of funding documentation. These grants provide flexibility to the grantee to propose activities and services based on their need. They are awarded based on an approved budget and reimbursed based on expending the budget. Although grants define eligibility and required activities, grantees propose the types of services and the service mix for individuals. This flexibility creates variation by grantee on the services delivered and how they are delivered.

Federal grant requirements share the following characteristics:

- PRSS are provided by individuals with lived experience who are in recovery from SUDs, a mental disorder, or co-occurring disorders. In some cases, family members are providers of PRSS.
- Grant funds provided directly to community provider organizations are allocated based on a proposed budget. Funds are used to support staff salaries and other expenses. Grants awarded to the Single State Authorities (e.g., ATR, state targeted response [STR], or SOR) can be contracted to local service providers using a variety of funding methods, including fee-for-service, cost reimbursement, and bundled program contracts. The subcontract agreement and funding method determine how the funds are tracked and billed.

Federal grant requirements showed minimal agreement on the following:

- The scope of work that peer recovery specialists should provide.
- Who supervises peer recovery specialists.
- Payment rate for PRSS or salaries for peer recovery specialists.

CHAPTER 3

Medicaid Financing and Utilization of Peer Recovery Support Services

Medicaid is a joint federal-state program that provides health coverage for low-income and disabled individuals. Each state can design and implement its own Medicaid plan, subject to federal guidelines and approval. As a result, peer recovery support services (PRSS) vary significantly across Medicaid state plans with no uniform standard in terms of definition, certification requirements, reimbursement rates, and supervision requirements.

A state-by-state analysis of several publicly accessible sources (such as state plan amendments and websites) was conducted from January to March 2023. For each state we identified individual (non-group) reimbursement rates, certification requirements, and supervision requirements for PRSS from relevant state Medicaid documentation, such as state plans, SB 30, SB 195, SB 803, HB 21-1021, 1115 waivers, and 1915 waivers. Sources included the following:

1

Fee-for-Service (FSS) Medicaid Fee Schedules

Fee schedules specific to mental health (MH) or substance use disorder (SUD) services, or both, were reviewed. The most common peer services billing code within the Centers for Medicare & Medicaid (CMS) Healthcare Common Procedure Coding System (HCPCS)[44] is H0038: Self-help and peer services, per 15 minutes. This search of Medicaid fee schedules yielded information about the following:

- Whether the state finances peer services for either MH or SUD services, both, or neither.
- Reimbursement rates for peer services specific to MH, SUD, or both.
- Whether the reimbursement rates for MH and SUD peer services differ in states where both are covered.

2

Authorization within State Plans

State authorization was determined by reviewing the state plan, the state's existing or pending Medicaid waivers as of March 2023, and enacted or pending bills related to MH or SUD (or both) peer services. For some states, these resources also yielded information regarding the financing of their peer recovery programs and certification or supervision requirements, or both.

3

State Peer Certification Board or Training Program Websites

When available, information regarding the state's peer specialist certification board or state-approved training programs was used to identify the certification or supervision requirements for peers, or both.

4

Transformed Medicaid Statistical Information System (T-MSIS) SUD Data Book

This resource was used to identify the utilization of PRSS by Medicaid beneficiaries by state from 2017 through 2020.

5

Press Releases, Announcements, or Medicaid State Announcements

When available, publicly accessible announcements, press releases, or other guidance released by state Medicaid programs for any information regarding the authorization, financing, certification, supervision, or other information related to MH or SUD (or both) peer programs and services was reviewed.

6

2023 Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States, published for SAMHSA by the Peer Recovery Center of Excellence

This resource was used for information on training or certification requirements for peers.

7

Copeland Center 2020 Peer Specialists Database

This research was used to supplement other information sources.

Overview of Medicaid Peer Support Findings

Medicaid reimbursement rates for PRSS vary greatly among states, with the lowest states reimbursing at less than 25 percent of the rate of the highest states for the same 15-minute service. Medicaid expansion states, on average, reimburse for peer support at higher rates than non-Medicaid expansion states. While peer support is available in nearly every state, and most states are using peer support for a larger proportion of Medicaid SUD cases in 2020 than in 2017, the deployment of peer support services for Medicaid beneficiaries remains low compared to other specialty SUD treatment services. Only five states provide PRSS for more than 5 percent of their Medicaid beneficiaries with a SUD. The findings present limited evidence of a relationship between reimbursement rates and utilization patterns as states that have higher reimbursement do not have the highest utilization. It is important to note that our findings may not capture all billed peer services. Peer support services may be utilized but bundled with other services and not billed directly in Medicaid encounter data.

Nearly All State Medicaid Plans Reimburse Peer Support under Medicaid Code H0038, Billed in 15-Minute Service Intervals

Rates vary significantly between states. In a few states the reimbursement rate varies by whether the peer support specialist is working with individuals with a mental or a substance use disorder.

Some states offer multiple positions or levels of certification for PRSS, with different reimbursement rates for each type of certification (e.g., Georgia, Ohio, and New York).

Several states do not allow for Medicaid to reimburse for peer support for individuals with mental disorders (e.g., Florida), SUD (e.g., Idaho), or both (e.g., South Dakota).

There is evidence of some states providing fee-for-service reimbursement for group-based peer support using other codes or modifiers; however, the practice is not widespread and is not included in this 50-state review.

The Certification and Prerequisite Requirements for Peer Recovery Specialists Differ between States

Nearly all states have a requirement for training hours, supervised work hours, or both, with the majority requiring between

40 and **80** combined hours.

Some states have established certification or credentialing processes for peer recovery support specialists. These processes may include training, education, supervision, testing, and continuing education requirements.

About half of the states require some work experience hours as part of their certification requirement. The number of hours varies from as low as

75 or **100** hours in Tennessee or South Carolina to as high as

2,000 hours in Oregon and Illinois

Some states do not have any formal certification requirements for PRSS and rely on informal or community-based recognition of their skills and experience.

9 States

Nine states have no exam requirement, while most states require passing a certification examination.

30 States

Thirty states do not allow peers to supervise other peers and instead require clinically trained professionals to provide supervision.

11 States

Of the Medicaid plans with specific guidance on the types of staff eligible to supervise peer providers, only 11 states allow for senior peers to be supervisors.

Medicaid Rates, Certification, and Supervisor Credential Requirements by State

Table 1 provides information by state on rates, certification, and supervisory requirements of peer support for SUD. Some states have multiple defined roles for PRSS, in which case the row will contain ranges of values. The table includes the following information:

- Medicaid Code H0038 (or nearest equivalent code) reimbursement rates per 15 minutes by MH or SUD self-help or peer services, or both.
- Certification requirements, including lived experience or recovery as a stated requirement, number of work experience hours, supervised work experience hours, and for completing an examination.
- Whether clinical professionals or senior peer providers are eligible to provide supervision.

Please note that some states may limit services to specific uses or settings, which is not captured in Table 1. Blank fields indicate that the rate or requirement was not available in the publicly accessible resources outlined above.

Table 1. 2023 State Medicaid rates, SUD certification, and supervisor credential requirements

	15-Minute FFS Rates		Certification Requirements					Supervisor	
State	MH	SUD	Lived Experience/ Recovery	Work Experience Hours	Training Work Hours	Supervised Work Hours	Pass Exam	Clinical	Peer
Alabama	$23.10	$9.00	Yes		40		Yes	X	
Alaska	$23.09	$23.09	Yes	1,000	50–65	25		X	
Arizona	$21.86	$21.86	Yes		Varies		Yes	X	
Arkansas	$16.77	$16.77	Yes	500	46	25	Yes	X	
California	$20.38	$20.38	Yes		80+		Yes		X
Colorado	$7.34	$7.34	Yes	500	60	25	Yes	X	
Connecticut	$13.02	$13.02	Yes	500	80		Yes		
Delaware	$14.75	$14.75	Yes	500	46	25	Yes		
District of Columbia	$23.33–25.77		Yes		70	80	Yes	X	
Florida	*	$9.75	Yes	500	40	16	Yes		
Georgia	$15.13–24.36	$15.13–24.36	Yes		40		Yes	X	
Hawaii	$15.19	$15.19	Yes		Varies		Yes	X	
Idaho	$13.63		Yes	500	46	25	Yes		X

* Reimbursement rate not listed in Florida 2023 Medicaid Fee Schedule.

	15-Minute FFS Rates		Certification Requirements					Supervisor	
State	MH	SUD	Lived Experience/ Recovery	Work Experience Hours	Training Work Hours	Supervised Work Hours	Pass Exam	Clinical	Peer
Illinois	$26.32	$13.22	Yes	2,000	100	100	Yes		X
Indiana	$8.55	$8.55	Yes		40		Yes	X	
Iowa	$12.50	$12.50	No	500	46	25	Yes		
Kansas	$16.02	$16.02	Yes		20		Yes	X	
Kentucky	$8.61	$8.61	Yes		30		Yes	X	
Louisiana	$12.61	$12.61	Yes		76		Yes	X	
Maine	$11.88	$11.88	Yes		64			X	
Maryland		$16.38	Yes	500	46	25	Yes		
Massachusetts	$16.92	$16.92	Yes	500	60	35	Yes	X	
Michigan		$20.00	Yes		40		Yes		
Minnesota	$15.02		Yes	500	46		Yes	X	
Mississippi	$7.83	$7.83	Yes	250	40		Yes	X	X
Missouri	$17.84	$17.84	Yes		35		Yes	X	
Montana	$14.01	$14.01	Yes		40		Yes	X	
Nebraska	$14.85	$14.85	Yes		60		Yes		
Nevada	$7.88	$7.88	Yes	475	46	25	Yes		X
New Hampshire	$24.94	$24.94	Yes	500	46	25	Yes	X	
New Jersey	$14.96	$14.96	Yes	500	46	25	Yes	X	
New Mexico	$15.54	$15.54	Yes		40	40	Yes	X	
New York	$23.46–26.32	$24.53–36.32	Yes	500	46	25	Yes	X	
North Carolina	$12.51	$12.51	Yes		60			X	
North Dakota	$7.55	$7.55	Yes	1,500	40				
Ohio	$25.09–36.32	$15.51	Yes		40		Yes	X	
Oklahoma	$9.75†	$9.75†	Yes		40		Yes	X	

† Oklahoma reimburses PRSS under Medicaid billing code H2015, "comprehensive community support services."

	15-Minute FFS Rates		Certification Requirements					Supervisor	
State	MH	SUD	Lived Experience/ Recovery	Work Experience Hours	Training Work Hours	Supervised Work Hours	Pass Exam	Clinical	Peer
Oregon	$24.78	$24.78	Yes	2,000	40			X	X
Pennsylvania	$10.00	$10.00	Yes		78		Yes		X
Rhode Island	$13.50	$13.50	Yes	500	46	25	Yes	X	X
South Carolina	$5.98	$5.98	Yes	100	40			X	
South Dakota									
Tennessee	$10.00	$10.00	Yes	75	40	75		X	X
Texas	$11.25	$11.25	Yes	250	46	250	Yes	X	X
Utah	$14.89	$14.89	Yes		40			X	
Vermont			Yes	500	46	25	Yes		X
Virginia	$19.50	$13.00	Yes	500	72	25	Yes	X	
Washington	$12.30	$12.30	Yes		36		Yes	X	
West Virginia		$15.07	Yes	500	46	25	Yes	X	
Wisconsin	$9.78	$9.78	Yes		48		Yes	X	
Wyoming	$9.00	$9.00	Yes	500	46	25	Yes		

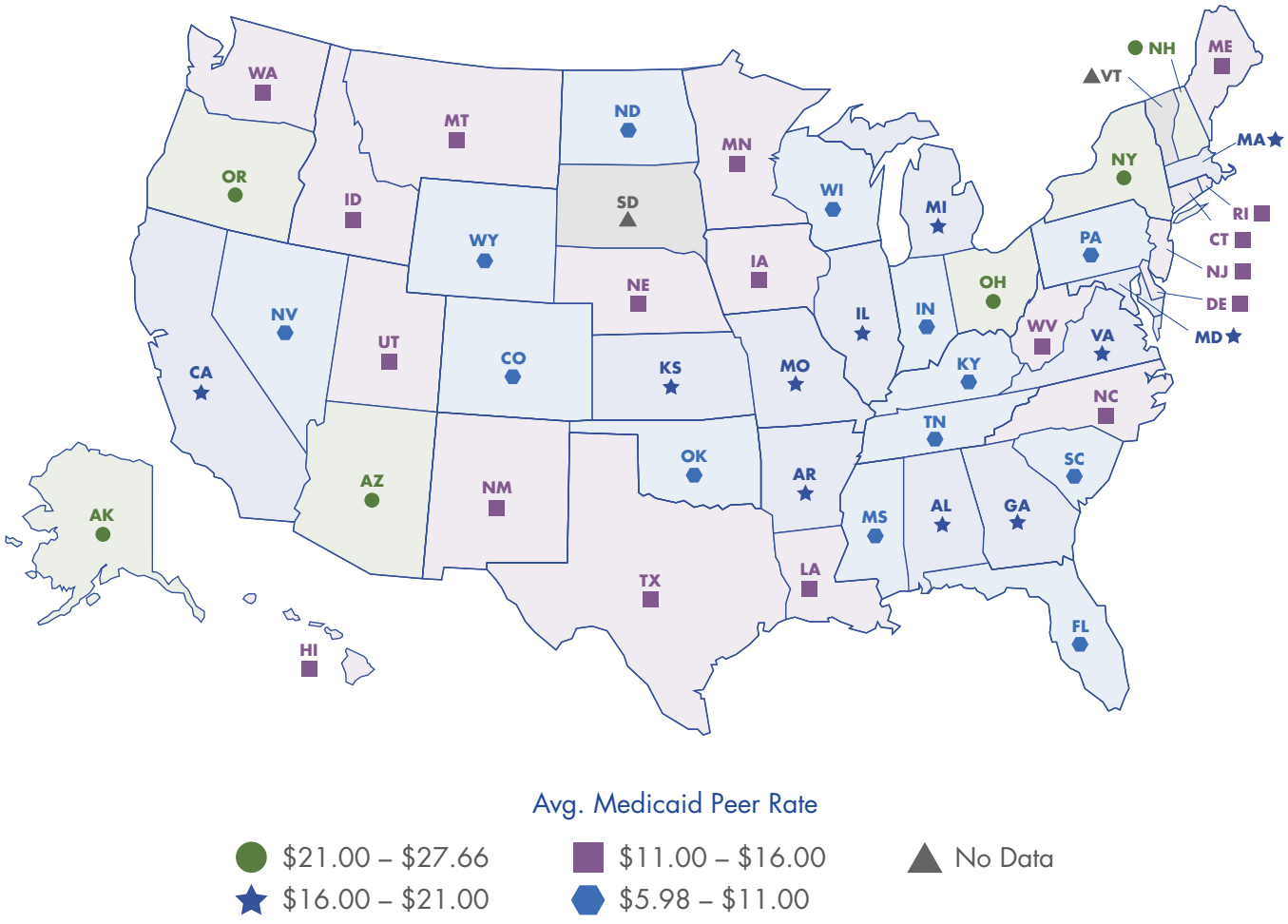
Note: The information in SAMHSA's Peer Recovery database is regularly updated. However, because each state handles its own certification processes, and they are ever-changing, it may occasionally have old information. If your state's information is out of date or if you have any questions, please contact Tim Saubers at tim.saubers@austin.utexas.edu.

Medicaid Reimbursement Varies by State

The range of Medicaid reimbursement rates for 15 minutes of peer support varies significantly by state, from as low as $5.98 in South Carolina to $27.66 in New York. The average rate across the 48 states with rates is $14.61 with a standard deviation of $5.16. Two states, South Dakota and Vermont, do not have Medicaid reimbursement rates for peer support that were uncovered by this review.

Exhibit 1 shows states according to their average peer reimbursement rate. Additionally, it is important to note that H0038 reimbursement only provides for direct service to a Medicaid beneficiary. It does not often capture PRSS such as outreach and engagement or community-based PRSS.

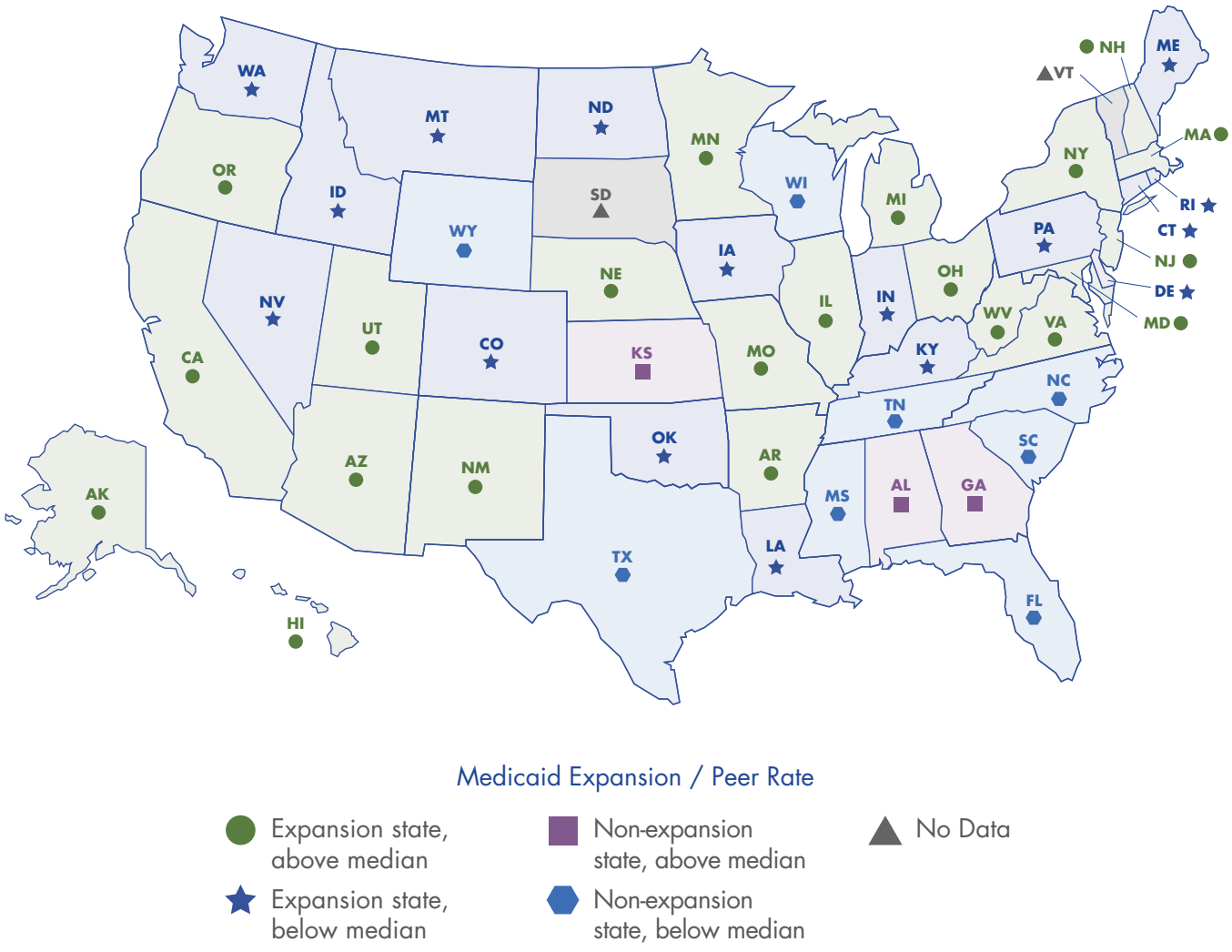
Exhibit 1. U.S. Medicaid reimbursement rate for PRSS, by state



Medicaid Expansion States Have Higher Reimbursement Rates for PRSS

States that have expanded their Medicaid program to allow for additional coverage of individuals resulting from the Affordable Care Act (ACA) have higher reimbursement rates for PRSS on average ($15.49, n=37) than non-expansion states ($11.63, n=11). Exhibit 2 shows that of the 11 states that have not yet expanded Medicaid, only 3 states exceed the median peer support reimbursement rate of $14.80. Of the 39 states that have expanded their Medicaid program, 21 states exceed the median peer support reimbursement rate.

Exhibit 2. States above and below median U.S. Medicaid reimbursement rate for PRSS, by Medicaid expansion



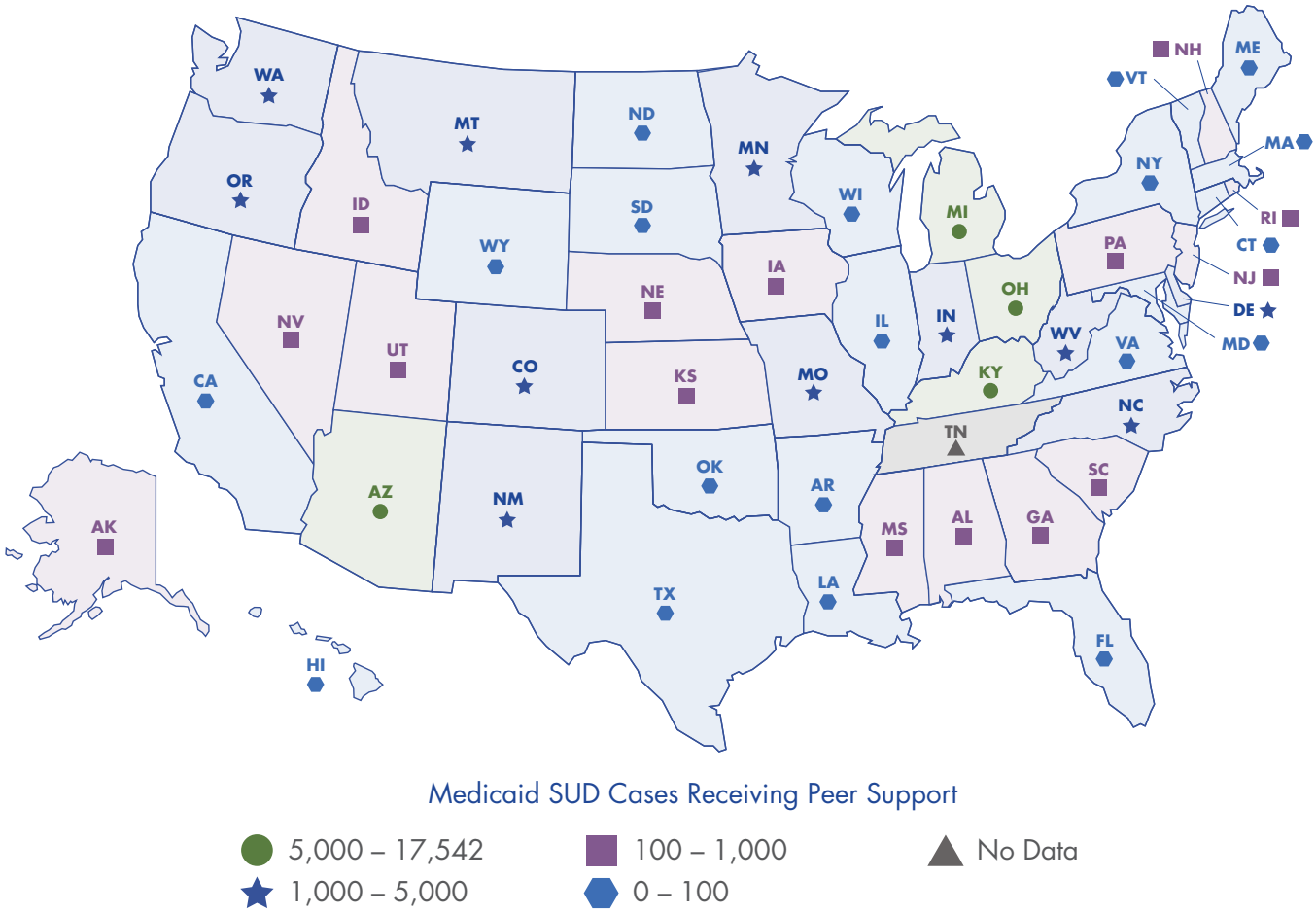
Few States Used Medicaid to Pay for Peer Support for More Than 5,000 Medicaid-Eligible Beneficiaries with a SUD

In the 2020 Transformed Medicaid Statistical Information System (T-MSIS) data, 84,532 Medicaid beneficiaries with a SUD received peer support, which represents 1.9 percent of all Medicaid SUD cases. As seen in Exhibit 3, the use of peer support for Medicaid SUD cases varies significantly by state. In 2020, data from 19 states showed fewer than 100 Medicaid SUD cases for peer support. Outlier states where peer support was billed for more than 5,000 Medicaid beneficiaries with a SUD include the following:

- Kentucky: 17,542 cases, 11.3%
- Arizona: 17,114 cases, 11.2%
- Michigan: 8,189 cases, 4.4%
- Ohio: 7,805 cases, 2.2%

Three states also had very high use of peer support in terms of percentage of Medicaid SUD cases treated: Delaware (2,029 cases, 9.6%), West Virginia (4,169 cases, 7.5%), and Montana (1,806 cases, 7.0%). These states do not appear in the highest category in Exhibit 3 due to their smaller total number of Medicaid SUD cases.

Exhibit 3. Medicaid SUD cases treated by PRSS



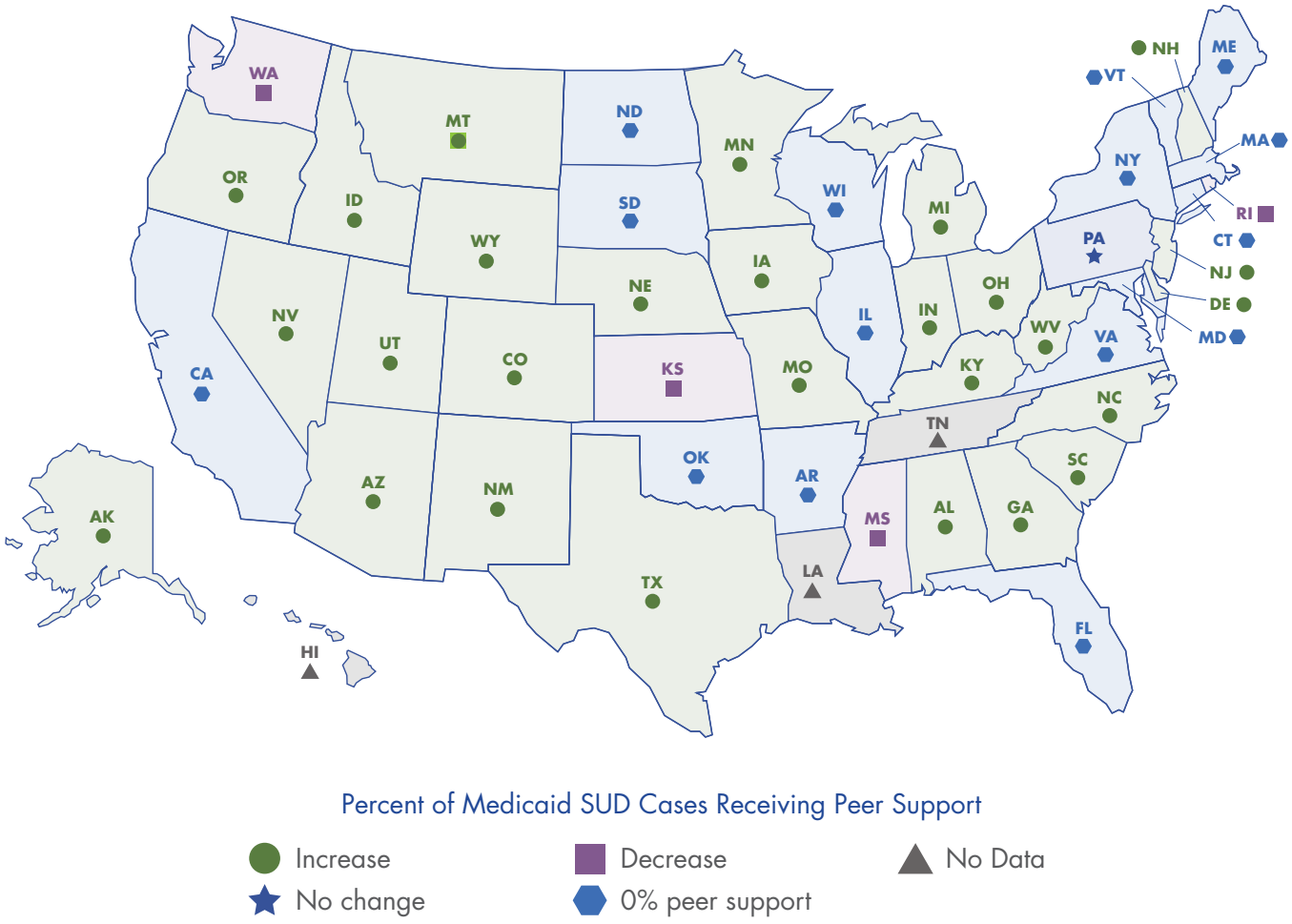
[i] It is important to note that this is not the quantity or full prevalence of PRSS for SUD being provided in communities, as significant amounts of PRSS are being deployed outside of the Medicaid program for a variety of reasons discussed in Chapter 4.

Most States are Increasing Use of Peer Support for SUD Under Medicaid

Since 2017, the overall percentage of Medicaid beneficiaries treated for a SUD with PRSS has increased by 1.1 percentage points from 0.8 percent in 2017 to 1.9 percent in 2020.[45] Exhibit 4 shows each state by whether its percentage of Medicaid SUD cases treated with peer support increased or decreased between 2017 and 2020. Twenty-seven states used peer support with a higher percentage of Medicaid funding in 2020 than in 2017. One state had no change in its use of peer support, 15 states used no peer support (that is, treated less than 0.1% of Medicaid SUD cases with peer support in both 2017 or 2020), 4 states show a decline in using peer support, and 3 states did not have data available in both years to make a comparison.

Some outlier states that increased PRSS usage by over 5 percentage points are Kentucky (8.7%), West Virginia (7.5%), and Delaware (6%). Some of the states' increases can be attributed to including PRSS as a Medicaid-covered service within the period, such as West Virginia (7.5%). State expansion of Medicaid in 2020 could account for some of the growth in Idaho in 2020 (3.1%).

Exhibit 4. States with increased and decreased Medicaid billing for SUD peer support, 2017–2020



Medicaid Beneficiaries Receiving PRSS for SUD Versus Other SUD Services

While PRSS is growing as a SUD support service, its use is still very low relative to other types of SUD services covered by Medicaid. The data presented in Exhibits 5 and 6 are from consecutive years of the T-MSIS SUD Data Book.[41] Exhibit 5 depicts the average number of Medicaid beneficiaries treated by service type across 4 years (2017-2020). Exhibit 6 depicts the number of beneficiaries treated by service type for each year.

Exhibit 5. Average Medicaid beneficiaries treated for SUD by service type, 2017–2020

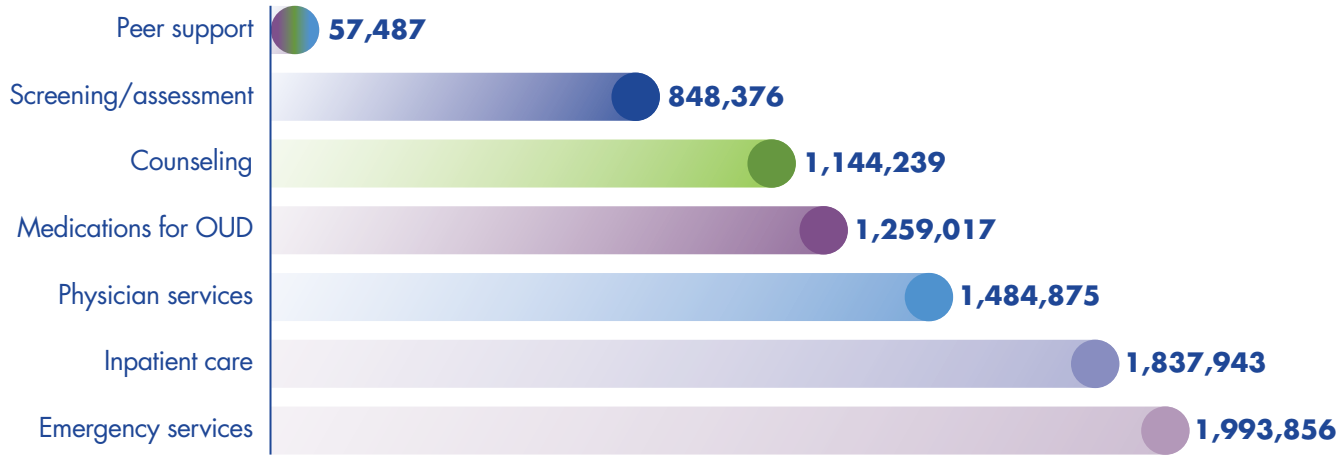
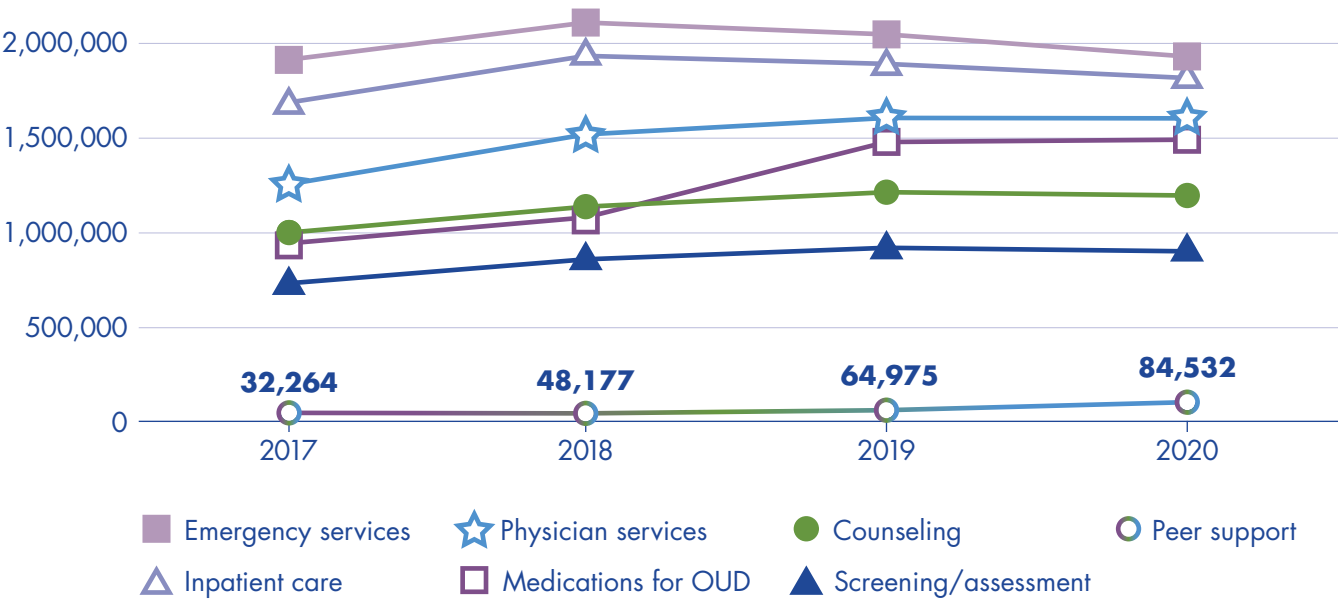


Exhibit 6. Number of Medicaid beneficiaries treated for SUD by service type, 2017–2020



CHAPTER 4

Short- and Long-Term Opportunities for Financing and Strengthening the Peer Recovery Support Services Workforce

As of this report's writing in 2023, 48 of 50 states are providing Medicaid coverage for peer recovery support services (PRSS), but use of this benefit is limited.[46] The limitation on use of PRSS may be due to a number of challenges in terms of variable reimbursement rates, certification requirements, and lack of knowledgeable supervisors.[31]

Fortunately, there are current efforts at the federal, state, and local community levels to address some of these challenges. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Recovery has developed a set of National Model Standards for Peer Support Certification, inclusive of mental health, substance use, and family peer support.[27]

The publication of these model standards aims to enhance the quality and consistency of PRSS practices across all states and supplement the existing workforce or contribute to its growth. However, the SAMHSA standards that address supervision[27] remain in conflict with 30 state Medicaid plan scope-of-practice regulations that still require a "mental health professional" to supervise PRSS.

This Chapter Summarizes the Input of a Technical Expert Panel

On May 25, 2023, SAMHSA convened a technical expert panel to:

- Review the findings from Chapters 1 through 3 of this report for accuracy.
- Identify challenges that limit the growth of the PRSS workforce despite Medicaid reimbursement for services.
- Identify short- and long-term opportunities to strengthen PRSS as part of the continuum of SUD services.

The panel included diverse perspectives and national expertise in mental health and SUD PRSS (see Appendix A for list of panel members).

The views of the panel do not necessarily reflect the views of SAMHSA or the federal government.

Factors That Prohibit the Broad Availability of PRSS[46]

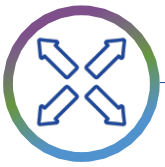
- Lack of employment and career path advancement opportunities for peer support specialists that provide a competitive and equitable living wage.
- Lack of training opportunities for PRSS in communities of color, rural, and other underserved communities.
- Lack of field experiences for newly trained peers to build skills and complete required certification hours.
- State Medicaid Plans, including exclusionary background checks (e.g., criminal background checks for those who may have a history of SUD) not taking into consideration the nature and qualifications for the role.
- Confusion about terminology and the different types of roles of peer workers such as community health workers, SUD peer recovery coaches, and mental health peer supporters.

Challenges with Growing the Peer Recovery Support Role

The panel identified the following challenges to growing the role, availability, and use of PRSS with Medicaid as the payer.

The National Provider Identifier as a Barrier

The overarching feeling was that a majority of peer recovery specialists are choosing not to become licensed to bill Medicaid because in most states they need to register for a National Provider Identifier (NPI). NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare & Medicaid (CMS). The requirements and steps needed to obtain the NPI feel daunting and incongruent with the values of PRSS.



Service Delivery Extends Outside of Medicaid Fee-for-Service Payment Structure

The complexity of fitting PRSS practice into (1) individual 15-minute pre-authorized increments, (2) a scope of practice, (3) requirements surrounding supervision, and (4) low reimbursement rates for Medicaid fee-for-service billing would need to be addressed to encourage growth of PRSS.

Infrastructure and Technology Capabilities Are Minimal

Given the non-clinical nature and minimal investment in infrastructure for PRSS, there has been limited adoption of electronic databases, mobile technology, and other data measurement and reporting tools that can be required when participating in a Medicaid billed service.

Undervaluing the Unique Contribution of Peers within a Clinical Treatment Model

The panel discussed the importance of "peerness" and a variety of ways to protect the PRSS to maintain its unique contributions in responding to individuals with SUDs. This need can conflict with traditional clinically driven treatment models since the PRSS practice is organized toward the recovery of an individual within a community. Further, the setting within which a peer is employed is vital to the overall satisfaction and quality of the PRSS services.

Lack of Diverse Representation in the Peer Workforce

The experts raised the need for the development of a more diverse peer workforce that is culturally congruent, competent, and more inclusive of people of color and LGBTQ+ communities. PRSS must be able to serve diverse communities with intentionality.

Short-Term Opportunities to Strengthen PRSS as Part of the Continuum of SUD Services

Panelists provided input on immediate steps that can occur in the next 1 to 2 years that could support the growth of PRSS and financing of the role. Their responses are summarized below. Developing career pipelines and pathways specific to peers was highlighted as foundational to nearly all the specific recommendations.

Unified Federal Agency Guidance

The Department of Labor, SAMHSA, Health Resources and Services Administration (HRSA), and CMS could collaborate to create a national database on peer recovery specialists' wages, health insurance reimbursement rates, and utilization rates (including types of funding used) on a biannual basis. This could provide the basis for further longer-term cost-benefit analysis of PRSS.

SAMHSA and HRSA could provide increased technical assistance to peer employers across all settings and encourage the use of grant funds and opioid abatement funds (opioid settlement funds allocated to states and localities to address the opioid crisis). These funds could provide care transformation support to recovery community organizations (RCOs) and community-based providers to improve their capabilities to use Medicaid as a sustainable funding source. Clear guidance is also needed to help identify or develop funding opportunities for training RCOs and growing the PRSS workforce.

SAMHSA and CMS could provide state substance use disorder (SUD) agency policy academies that bring together state policymakers to explore the intersection of their state grant contract requirements for PRSS and their state Medicaid plan to identify any conflicts. In addition, these policymakers could evaluate and compare their peer support Medicaid rates and billing requirements.

CMS Guidance

CMS could amend policies so that prior authorization by a licensed practitioner is not required for delivering peer support, especially for outreach and engagement activities.

Further, CMS could clarify through a guidance letter to all states and Managed Care Organizations (MCO) several policies that align with learnings from the SAMHSA grant investments and National Model Standards. The letter should emphasize the following:

- PRSS may be authorized by a state to be an In Lieu of Services and Settings (ILOS) if the state determines that it is a medically appropriate and cost effective substitute for a covered state plan service. Managed care plans may elect to offer ILOSs authorized by the state and provide enrollees the option to utilize them. Use of ILOSs to address health-related social needs was described in the CMS State Medicaid Director's Letter (SMDL) issued January 4, 2023.[47] The SMDL highlights ways community-based providers can work with states and managed care plans to improve population health, reduce health inequities, and lower health care costs in Medicaid. Clarifying that some states may determine PRSS an ILOS could encourage and increase access.
- Additional opportunities and examples on how peer-run RCOs could participate in the Medicaid program at the facility level.
- Peers with advanced experience in program oversight can provide direct supervision to peer recovery specialists, and supervision by a clinical professional is not required.
- PRSS can be deployed flexibly and is considered a key secondary prevention or early intervention tool for individuals who might not meet the clinical criteria for more acute treatment.
- A recovery plan, rather than a clinical treatment plan, is allowable for Medicaid beneficiaries to engage in PRSS.
- Technology-enabled PRSS is acceptable, such that services offered by phone, text, or email are acceptable and billable interactions.

State Scope of Practice Laws

States can update their scope of practice laws in accordance with the National Model Standards. The Office of National Drug Control Policy could also publish a model state scope of practice regulation to help expedite this process.

Support Diverse Representation in the Peer Workforce

SAMHSA or other agencies can offer specific grants to community-based providers to promote inclusivity and recruit people of color and the LQBTQ+ communities to the peer recovery support workforce.

Long-Term Opportunities to Strengthen PRSS as Part of the Continuum of SUD Services

Panelists provided input on longer-term (2- to 5-year) steps that could enhance the growth of PRSS and financing of the role. Their input is summarized below.

Develop Standard Occupational Classification Codes

The Department of Labor could develop a standard occupational classification code[48] specific for peer support. Currently, peer support is co-mingled and tracked with community health workers (CHW). Peer recovery specialists and CHW provide distinct services that are not reliant upon the same scope of practice, services, and supports.

Provide Funding for Development

Funding for workforce development and business skill development should be deployed through a variety of sources similar to Health Information Technology (HIT) Meaningful Use,[49] which provided hospitals and eligible clinicians incentives to meaningfully utilize certified electronic health record technology to support high value and quality care.

Data Collection and Cost-Benefit Analyses

Stakeholders should conduct and disseminate cost-benefit analyses to advance the reimbursement rates and salaries in the field, and jointly align outcome metrics. SAMHSA should enhance grantee and state data collection to include collection of information specific to financing and using PRSS.

Use of Innovative Payment Models

The Center for Medicare & Medicaid Innovation could develop a demonstration project to test Alternative Payment Model (APM) designs for PRSS, similar to the Integrated Care for Kids (InCK) Model[50] or The Maternal Opioid Misuse (MOM) Model.[51] State Medicaid Authorities can facilitate the adoption of APMs for PRSS by providing MCO specific guidance, including it in their MCO contracts and in conjunction with 1115 waivers focused on SUD.[52] These arrangements should explore bundled and capitated payment arrangements where PRSS can be tailored to the specific service needs of the community.

Panel Conclusions

Panel members overwhelmingly endorse the role of PRSS to help individuals with SUDs. They noted that the way that PRSS was described and implemented in SAMHSA grant programs is the way that it should be delivered despite payer type. The panel did caution against workforce growth in a way that is detrimental to the profession or does not support the sustainability and advancement of authentic peer roles across settings. The panelists emphasized that the critical role of peers in the care continuum must be treated with the same respect as their clinical counterparts. They noted that peer recovery specialists are best incorporated into SUD service delivery when they are supported by a trained supervisor familiar or experienced in delivering PRSS.

Conclusion

While the prevalence and utilization of PRSS has increased over recent years, the variation and inconsistency in financing are inhibiting the growth of the profession and promoting fragmented, unsustainable models of peer support care. The overarching belief of the expert panel is that the Medicaid fee-for-service financing of PRSS provides the most daunting challenge to scaling the peer workforce and meeting the increasing demand for peer support. Other major challenges include infrastructure, low compensation, and lack of innovative payment methodology use. There are many opportunities to overcome the various challenges associated with enhancing and supporting the PRSS workforce, as noted in this report.

The ongoing overdose crisis, research on the value and effectiveness of PRSS, and the prevalence of individuals living in recovery, provide a significant opportunity to address the community response to alcohol and other SUDs. Further efforts and new and updated guidance from SAMHSA, CMS, and other federal and state stakeholders could help support and expand the peer SUD workforce.

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APPENDIX A

Members of the Expert Panel

SAMHSA conducted a virtual panel titled "Financing Peer Recovery Support: The Opportunity to Enhance the Substance Use Disorder Workforce" on May 25, 2023. The objective of the panel was to gather valuable input from expert panelists, aiming to assist SAMHSA in finalizing the publication and providing guidance on improving the financing and support for peer recovery specialists and coaches within the continuum of care.

The panel consisted of seven individuals who possessed expertise in peer recovery support services, substance use disorders, health care financing, and payment models. By collaborating with these esteemed individuals, SAMHSA was able to gather invaluable insights and expertise to enhance the understanding and implementation of financing strategies for peer recovery support services.

The following expert panelists made significant contributions to the successful execution of the panel:

Robert Ashford
Founder and CEO, RecoveryLink, and Executive Director, Unity Recovery

Amy Brinkley
Recovery Support Systems Coordinator, National Association of State Mental Health Program Directors (NASMHPD)

Sierra Castedo
Postdoctoral Fellow, JEAP Initiative

Johanna Dolan
Founder and CEO, Dolan Research International

Dana Foglesong
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Joe Powell
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APPENDIX B

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APPENDIX C

Additional Data Tables

Number and percentage of Medicaid beneficiaries in 2020 with a SUD served via PRSS

State	Number of Medicaid Beneficiaries with a SUD Served by Peer Support, 2020	Percent of Medicaid Beneficiaries with a SUD Who Received Peer Support, 2020	Difference in Percentage, 2017–2020 (Percentage Points)
Alabama	230	0.5%	0.5%
Alaska	159	0.9%	0.4%
Arizona	17,114	11.2%	0.2%
Arkansas	12	0.0%	0.0%
California	DS	DS	0.0%
Colorado	1,202	1.4%	DS
Connecticut*	0	0.0%	0.0%
Delaware	2,029	9.6%	6.0%
District of Columbia*	0	0.0%	DS
Florida	32	0.0%	0.0%
Georgia	314	0.5%	0.1%
Hawaii	DS	DS	DS
Idaho	822	3.1%	3.1%
Illinois*	0	0.0%	0.0%
Indiana	1,779	1.6%	1.5%
Iowa	280	0.5%	0.4%
Kansas	798	3.8%	-0.7%
Kentucky	17,542	11.3%	8.7%
Louisiana*	0	0.0%	DS
Maine*	0	0.0%	0.0%
Maryland*	0	0.0%	0.0%
Massachusetts	29	0.0%	0.0%
Michigan	8,189	4.4%	1.0%
Minnesota	3,688	3.8%	3.7%
Mississippi	416	1.6%	DS

State	Number of Medicaid Beneficiaries with a SUD Served by Peer Support, 2020	Percent of Medicaid Beneficiaries with a SUD Who Received Peer Support, 2020	Difference in Percentage, 2017–2020 (Percentage Points)
Missouri	2,532	4.0%	DS
Montana	1,806	7.0%	DS
Nebraska	102	0.8%	DS
Nevada	918	1.9%	1.3%
New Hampshire	389	1.9%	1.5%
New Jersey	259	0.3%	0.3%
New Mexico	1,160	1.8%	1.8%
New York	47	0.0%	0.0%
North Carolina	2,272	2.1%	1.2%
North Dakota*	0	0.0%	0.0%
Ohio	7,805	2.2%	DS
Oklahoma*	0	0.0%	0.0%
Oregon	4,607	4.7%	0.2%
Pennsylvania	211	0.1%	0.0%
Rhode Island	395	1.8%	-0.7%
South Carolina	716	1.7%	1.4%
South Dakota*	0	0.0%	0.0%
Tennessee	DQ	DQ	DQ
Texas	72	0.1%	0.1%
Utah	647	2.2%	1.8%
Vermont*	0	0.0%	0.0%
Virginia	DS	DS	DS
Washington	1,717	1.2%	-0.2%
West Virginia	4,169	7.5%	7.5%
Wisconsin*	0	0.0%	0.0%
Wyoming	73	2.1%	DS

Source: T-MSIS SUD Data Books 2017 and 2020.

*State did not have claims for Peer Support Services in 2020.

DS: Data suppressed for confidentiality reasons because the group included fewer than 11 beneficiaries.

DQ: Data not reported due to severe quality issue.

State guidelines for PRSS recertification and supervision

State	Retraining, Recertification, Continuing Education*	Supervisory Training*	Family Member or Friend PRSS
Alabama	16 hours		No
Alaska			Yes
Arizona	Yes	Yes	Yes
Arkansas	18 hours	Yes	No
California	10 hours		Yes
Colorado	30 hours		No
Connecticut*	10 hours	Yes	Yes
Delaware	20 hours	Yes	Yes
District of Columbia*			No
Florida	Yes	Yes	Yes
Georgia	16 hours	Yes	
Hawaii			
Idaho	116 hours	Yes	No
Illinois*	Yes	Yes	Yes
Indiana	54 hours	Yes	Yes
Iowa	20 hours		No
Kansas	Yes		No
Kentucky	6 hours	13 hours	Yes
Louisiana*	Yes	Yes	No
Maine*		Yes	Yes
Maryland*	20 hours	Yes	Yes
Massachusetts	30 hours	Yes	No
Michigan		Yes	No
Minnesota	20 hours	Yes	Yes
Mississippi	Yes	32 hours	Yes
Missouri	20 hours	8 hours	Yes
Montana	Yes	20 hours	

State	Retraining, Recertification, Continuing Education*	Supervisory Training*	Family Member or Friend PRSS
Nebraska	Yes		
Nevada	20 hours		No
New Hampshire	14 hours	18 hours	Yes
New Jersey	20 hours		No
New Mexico	80 hours		No
New York	20 hours	Yes	
North Carolina	20 hours	18 hours	No
North Dakota	Yes	Yes	Yes
Ohio	30 hours	20 hours	No
Oklahoma	12 hours	Yes	No
Oregon	20 hours		No
Pennsylvania	20 hours	Yes	Yes
Rhode Island	20 hours	Yes	Yes
South Carolina	20 hours		No
South Dakota			
Tennessee	35 hours	Yes	No
Texas	20 hours	Yes	No
Utah	20 hours	Yes	No
Vermont		Yes	Yes
Virginia	20 hours	Yes	Yes
Washington	Yes		Yes
West Virginia	20 hours		No
Wisconsin	20 hours	Yes	No
Wyoming	5 hours		No

Sources: Authorization within State Plans, State Peer Certification Board or Training Program Websites, Medicaid State Announcements, and SAMHSA State-by-State Directory of Peer Recovery Coaching, Training, and Certification Programs Report.

* States with "Yes" mention the requirement but without specifying number of hours.

Table 1. 2023 State Medicaid rates, SUD certification, and supervisor credential requirements

	15-Minute FFS Rates		Certification Requirements					Supervisor	
State	MH	SUD	Lived Experience/ Recovery	Work Experience Hours	Training Work Hours	Supervised Work Hours	Pass Exam	Clinical	Peer
Alabama	$23.10	$9.00	Yes		40		Yes	X	
Alaska	$23.09	$23.09	Yes	1,000	50–65	25		X	
Arizona	$21.86	$21.86	Yes		Varies		Yes	X	
Arkansas	$16.77	$16.77	Yes	500	46	25	Yes	X	
California	$20.38	$20.38	Yes		80+		Yes		X
Colorado	$7.34	$7.34	Yes	500	60	25	Yes	X	
Connecticut	$13.02	$13.02	Yes	500	80		Yes		
Delaware	$14.75	$14.75	Yes	500	46	25	Yes		
District of Columbia	$23.33 – 25.77		Yes		70	80	Yes	X	
Florida	*	$9.75	Yes	500	40	16	Yes		
Georgia	$15.13 – 24.36	$15.13 – 24.36	Yes		40		Yes	X	
Hawaii	$15.19	$15.19	Yes		Varies		Yes	X	
Idaho	$13.63		Yes	500	46	25	Yes		X
Illinois	$26.32	$13.22	Yes	2,000	100	100	Yes		X
Indiana	$8.55	$8.55	Yes		40		Yes	X	
Iowa	$12.50	$12.50	No	500	46	25	Yes		
Kansas	$16.02	$16.02	Yes		20		Yes	X	
Kentucky	$8.61	$8.61	Yes		30		Yes	X	
Louisiana	$12.61	$12.61	Yes		76		Yes	X	
Maine	$11.88	$11.88	Yes		64			X	
Maryland		$16.38	Yes	500	46	25	Yes		
Massachusetts	$16.92	$16.92	Yes	500	60	35	Yes	X	
Michigan		$20.00	Yes		40		Yes		
Minnesota	$15.02		Yes	500	46		Yes	X	
Mississippi	$7.83	$7.83	Yes	250	40		Yes	X	X
Missouri	$17.84	$17.84	Yes		35		Yes	X	

* Reimbursement rate not listed in Florida 2023 Medicaid Fee Schedule.

	15-Minute FFS Rates		Certification Requirements					Supervisor	
State	MH	SUD	Lived Experience/ Recovery	Work Experience Hours	Training Work Hours	Supervised Work Hours	Pass Exam	Clinical	Peer
Montana	$14.01	$14.01	Yes		40		Yes	X	
Nebraska	$14.85	$14.85	Yes		60		Yes		
Nevada	$7.88	$7.88	Yes	475	46	25	Yes		X
New Hampshire	$24.94	$24.94	Yes	500	46	25	Yes	X	
New Jersey	$14.96	$14.96	Yes	500	46	25	Yes	X	
New Mexico	$15.54	$15.54	Yes		40	40	Yes	X	
New York	$23.46 – 26.32	$24.53 – 36.32	Yes	500	46	25	Yes	X	
North Carolina	$12.51	$12.51	Yes		60			X	
North Dakota	$7.55	$7.55	Yes	1,500	40				
Ohio	$25.09 – 36.32	$15.51	Yes		40		Yes	X	
Oklahoma	$9.75†	$9.75†	Yes		40		Yes	X	
Oregon	$24.78	$24.78	Yes	2,000	40			X	X
Pennsylvania	$10.00	$10.00	Yes		78		Yes		X
Rhode Island	$13.50	$13.50	Yes	500	46	25	Yes	X	X
South Carolina	$5.98	$5.98	Yes	100	40			X	
South Dakota									
Tennessee	$10.00	$10.00	Yes	75	40	75		X	X
Texas	$11.25	$11.25	Yes	250	46	250	Yes	X	X
Utah	$14.89	$14.89	Yes		40			X	
Vermont			Yes	500	46	25	Yes		X
Virginia	$19.50	$13.00	Yes	500	72	25	Yes	X	
Washington	$12.30	$12.30	Yes		36		Yes	X	
West Virginia		$15.07	Yes	500	46	25	Yes	X	
Wisconsin	$9.78	$9.78	Yes		48		Yes	X	
Wyoming	$9.00	$9.00	Yes	500	46	25	Yes		

† Oklahoma reimburses PRSS under Medicaid billing code H2015, "comprehensive community support services."

Note: The information in SAMHSA's Peer Recovery database is regularly updated. However, because each state handles its own certification processes, and they are ever-changing, it may occasionally have old information. If your state's information is out of date or if you have any questions, please contact Tim Saubers at tim.saubers@austin.utexas.edu.

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